MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Baylor All Saints Medical Center C/o Advanced Practice, Inc. 17101 Preston Rd., Suite 180-S Dallas, TX 75248	MDR Tracking No.: M4-03-9598-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Highmark Casualty Ins. Co./Rep. Box #: 19 C/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX 78701	Date of Injury: Employer's Name: HEP Management Inc Insurance Carrier's No.: 0705915A064060301I

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8-26-02	8-31-02	Inpatient Hospitalization	$40,700.19	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position summary of July 28, 2003 states, "On behalf of Baylor All Saints Medical Center, we have reviewed the claim and payment for the above hospital admission. Our findings reveal this claim has not been paid according to the hospital fee guideline published by TWCC…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position summary of August 20, 2003 states, "… the $40,000 threshold has been exceeded, but the Requestor has not proven entitlement to the preferred per diem method. The Hospital must show that the services provided were unusually extensive and unusually costly. The records provided do not indicate treatment that was unusually extensive or costly. In the absence of such evidence, the favored and the default method of reimbursement is the per diem method…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services". The UB-92 list the "Prin Diag" code as "722.52"; lumbar disc degeneration. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 5 days (consisting of 4 surgical days and 1 day intermediate ICU). Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118) and $1,560.00.00 (1 times $1,560) for a total of $6,032.00. The Respondent paid $6,032.00. In addition, the hospital is entitled to additional reimbursement for implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The Respondent reimbursed $16,967.50 for Rev. Code 278 (implantables). The Requestor submitted an invoice for review dated September 25, 2002. The implants identified, were sold to All Saints Episcopal Hospital in Fort Worth, TX and shipped to All Saints Episcopal Hospital in Fort Worth, TX with no patient identification. The submitted UB-92 indicates the service was provided at Baylor All Saints Medical in Dallas, TX. Therefore, the invoice of September 25, 2002 is not considered in this review. The requestor did not submit any medical documentation nor any invoices for this inpatient hospitalization; therefore, MDR cannot determine the cost plus 10%.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for the admission.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Roy Lewis	6-16-05
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____